DOH-BES
61AD-7/05

MEDICAL ADDENDUM

Utah Department of Health

Case Name _____ Case Number _____

ASSETS - List any assets you own or owned by anyone who lives with you. Assets are bank accounts, cash, stocks/bonds, life insurance/burial funds, homes, property, livestock, trailers, trust funds, etc. Include any personal household items that could be sold for $500 or more. ***List vehicles in the second section.***

Type of Asset	Owners	Joint? Y/N	Value	Amount Owed

VEHICLES (Car Snowmobile MotorCycle Other Vehicle Truck/Van Motor Home Boats/Motors)

Type of Vehicle	Make	Model	Year	Licensed Yes/No Lic. # / State	Owner/ Joint Owners	Amount Owed	Current Value

ELIGIBILITY -

✎ Is everyone in your home a Utah resident? . . . . . ☐ Yes ☐ No
If no, explain _____

✎ Has anyone in your home receive medical services in the past 90 days? . . . . . ☐ Yes ☐ No
If yes, explain _____

✎ Has anyone received Financial Assistance in the past 4 months? . . . . . ☐ Yes ☐ No
If yes, Who_____ When_____ Where _____

✎ Do you have a friend or relative you would like to help you with your case? . . . . . ☐ Yes ☐ No
If yes, give name, address, and phone_____

✎ Is anyone over 18 attending school? . . . . . ☐ Yes ☐ No
If yes, list names and schools attended. _____

✎ Is anyone in your home pregnant? . . . . . ☐ Yes ☐ No
If yes, give name and due date._____

✎ Is anyone in your home disabled? . . . . . ☐ Yes ☐ No
If yes, give name._____

INCOME - EARNED INCOME

NAME				NAME			
Date Started	Hours Worked per Week	Hourly Wage	Day of Month/Wk Paid	Date Started	Hours Worked per Week	Hourly Wage	Day of Month/Wk Paid

✎ If you are employed, when did you start?_____

✎ Do you expect any changes in earnings or number of hours worked? . . . . . ☐ Yes ☐ No
If yes, explain: _____

OTHER INCOME

✎ Does anyone in the household receive any other income (child support or alimony, unemployment, Social Security, Retirement, Self-employment, etc)? . . . . . ☐ Yes ☐ No
If yes, Give names and amounts. _____

✎ Has anyone in the household received SSI and then stopped receiving it? . . . . . ☐ Yes ☐ No
If yes, list name, date and reason SSI stopped: _____

✎ Has anyone applied for SSI, SSA, VA, Unemployment, or Worker's Compensation? . . . ☐ Yes ☐ No
If yes, explain_____

✎ Does anyone help you pay mortgage/rent, food, or utility bills? . . . . . ☐ Yes ☐ No
If yes, explain_____

✎ Does someone in the household work in exchange for mortgage/rent, food, or utility bills? ☐ Yes ☐ No
If yes, explain _____

EXPENSES

✎ Is child support or alimony paid by someone in your household who is a spouse or parent of a disabled person? . . . . . ☐ Yes ☐ No
If yes, list name and amount paid: _____

✎ Does anyone in the household pay for dependent care so they can go to work? . . . . . ☐ Yes ☐ No
If yes, list names and amounts: _____

THIRD PARTY AND INSURANCE INFORMATION

Name: _____ Birthdate: _____ Case#: _____

1. Does anyone in your home currently have health insurance including Medicare? Yes No
   If you answered yes, complete Section 1.

2. Has anyone had Insurance that has ended in the past 6 months? Yes No
   If you answered yes, enter the information in Section 2.

3. Do you have insurance available which you have not enrolled in? Yes No
   If you answered yes, complete Section 2.

4. Does someone in your home have a major medical need*? Yes No
   Who has the medical need?_____ What is the medical need?_____
   If yes, do you have: 1. Insurance available which you have not purchased? Yes No
   2. Insurance that has ended in the past 60 days? Yes No
   *Pregnancy is considered a major medical need. If you answered yes, enter the information in Section 2.

5. Have you or any household member been injured in an accident or assault? Yes No
   If you answered yes, complete Section 3.

6. Is any other person required to pay medical expenses for anyone in your household? Yes No
   If yes, person's name _____ Phone Number_____

7. Has anyone in your household ever served in the military? Yes No
   Name_____ Dates of Service _____

Section 1 - Insurance Information (If you answered NO to question 1, do not complete this section)

Name of Insurance Company_____ Phone #_____
Address of Insurance Company _____ Group # _____
Policyholder Name _____ Policy # _____
Policyholder Date of Birth _____ Policyholder Social Security Number _____
If insurance is through an employer, list employer name and phone _____
Premium $_____ Date Due_____ How Often? _____
Names of Individuals Covered:

Name of 2nd Insurance Company_____ Phone #_____
Address of Insurance Company _____ Group # _____
Policyholder Name_____ Policy #_____
Policyholder Date of Birth _____ Policyholder Social Security Number _____
If insurance is through an employer, list employer name and phone _____
Premium $_____ Date Due_____ How Often? _____
Names of Individuals Covered (if not listed on the insurance card):

Section 2 - Buy-Out/PCN Information

Name and Phone of Insurance Company_____
Policyholder Name_____ Policy # _____
Employer Name & Phone (if applicable) _____
If not through an employer, how is insurance available?_____

Section 3 - Accident or Assault Information (If you answered NO to question 5, do not complete this section)

Please check the type of incident: ☐ automobile ☐ assault ☐ work-related ☐ slip/ fall ☐ dog bite
☐ medical malpractice ☐ other, please explain_____
Name of person(s) injured:_____Date
of incident:_____Was a police report filed? ❑ Yes ❑ No
Police department: _____ Police Report Number: _____
Name of Attorney: _____ Phone number: _____

☞BEFORE YOU SIGN THIS APPLICATION, BE SURE YOU UNDERSTAND THIS INFORMATION☜ 4

- ❍ I assure that all of the members of my household are U.S. citizens or aliens in lawful immigration status, unless I am requesting emergency medical assistance only. The Department of Health will verify alien registration numbers with the Immigration and Naturalization Service (INS). The Department will not report undocumented household members to INS.

- ❍ All the members of my household will obey the medical assistance program rules. If I receive medical assistance which I am not eligible to receive, I will be responsible for repaying the medical assistance. I will allow only the people named on the medical card to use the medical card.

- ❍ If the Utah Department of Health pays for my medical care, I assign to it my rights to payments from any third party and to benefits for medical services. I will give to the Department any money I collect from an insurance policy or from someone required to pay for my medical expenses. I authorize payment directly to the Department of Health or the Office of Recovery Services and will hold harmless any party making payment to them. I agree to cooperate with the State of Utah to establish medical support for my family and in pursuing any third party responsible for medical expenses. I agree to cooperate with the State of Utah to establish and collect alimony and child support for my family unless I have good cause.

- ❍ I agree that the assistance I receive under any medical program is limited to that described in the Provider Manuals that the Utah Department of Health has written. I understand that the benefits I am eligible to receive may be changed without my knowledge or consent. I further agree to be responsible for any co-pays to providers at the time of medical service unless I am exempt from those co-pays.

- ❍ I authorize any person or organization to release medical records or information about my health or the health of my dependents to the Department of Health, Division of Health Care Financing or designee. The Department of Health and the Department of Workforce Services may give health care providers information about my eligibility for medical assistance.

- ❍ The State has the right to recover from my estate all money spent to pay my medical bills if I receive Medicaid at any time while I am 55 years of age or older.

- ❍ I give permission for ANY INFORMATION LISTED ON THIS FORM TO BE VERIFIED. My medical benefits may be reduced, denied, or stopped because of information received. I understand that failure to report changes and any false information given on this application, or subsequently provided, may result in prosecution for fraud. I understand that I may ask for a fair hearing if I disagree with the decision made on this application. For more information on fair hearings so your Rights and Responsibilities on the next page.

**** *I (print name) _____, read or had read to me the statements on this page. I understand those statements. Under penalty of perjury, I swear that the answers I have given on this application are complete and correct. I am the person represented by the signature on this document.*

_____	_____	_____
Signature or Mark of the Applicant	Signature of the Spouse or Representative	Date

VOTER REGISTRATION INFORMATION

If you are not registered to vote where you live now, would you like to apply to register to vote here today? ☐ Yes ☐ No

If you do not check either of these boxes, we will assume you have decided not to register to vote at this time. You may fill out the application form in private. If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. Choosing to register or declining to register to vote will not effect the amount of assistance that you will be provided by this agency. If you believe that someone has interfered with your right to register, your right to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with Lt. Governor, State of Utah, 203 State Capitol Building, Salt Lake City, UT 84114. *Action Taken*_____

This Section To Be Completed By The Worker Worker Name_____

☐ Exploring Medicaid	☐ Medicare Cost Sharing (QMB, SLMB, QI-1)	☐ Rights & Respons/476
☐ Estate Recovery (55+)	☐ Medicaid For Those With Disabilities & PCN	☐ Health Risk Assessment
☐ ASVS	☐ Duty of Support _____	☐ Health Plan/PCP_____
☐ Tobacco Survey	☐ HIPAA Form	☐ Mental Health Booklet

Application Status ☐ Approved ☐ Denied - Reason_____ Date_____

Comments:_____

Please tear off the following pages for your information.

Your Rights and Responsibilities

Your have the right to:

- Apply or reapply any time you wish for any medical program offered by the Department of Health. Applications for PCN, Covered At Work, and CHIP are only accepted during open enrollment periods. Someone else may help you apply, if you need help.

- Receive a notice that we have either approved or denied your application and the reasons for the decision. For medical assistance, we have 30 days to process your application, or 90 days if you claim to be disabled, unless you need more time.

- Receive a notice if we reduce, stop or hold your assistance and why. In most cases, we most cases we must mail the notice 10 days before we do this.

- Do the following things if you do not agree with decisions made regarding your case:
  A. Talk to your worker. Make sure you are not misunderstanding each other.
  B. Talk to your worker's supervisor.
  C. Talk to Constituent Services. Salt Lake 538-6417 or call toll-free 1-877-291-5583.
  D. Request a Fair Hearing within 90 days of the decision; 10 days to get benefits while the hearing is held. If you were denied disability status, you may also ask for a reconsideration as part of the fair hearing. If SSA denied your disability, you would have to go through their appeal process.
  E. Request legal representation regarding your fair hearing. You may be entitled to free legal assistance from Utah Legal Services. In Ogden, 394-9431; Salt Lake, 328-8891. The toll free number is 1-800-662-2538. You may also receive a referral for legal advice from the Salt Lake Lawyer Referral at 531-9075.

- Look at information in your case. Information about you and your case is confidential. Information may be given to other agencies to administer a program to help you.

Your Responsibilities:

- **Verify Information**
  The Social Security Act (U.S.C. 1320 b - 7 (a) (1) requires that you give us a Social Security number for each household member who wants medical assistance. If you do not have a number, you must prove you have applied. You may be eligible for assistance while you are waiting to receive a number. If you are applying only for emergency Medicaid, you do not have to have a Social Security Number.

  Your Social Security number will be used with the State Income and Eligibility Verification System to make sure that your household is eligible for federal assistance programs. Computer matching, program reviews, and audits will be done with Job Service, Immigration and Naturalization, Social Security, and Internal Revenue Service records. We may also do inquiries to banking and loan institutions and any other organizations or individuals who may have eligibility information about your household. You must give us proofs to show that you are eligible for assistance. If you do not understand what we need or you cannot give us the proof we are asking for, talk to your worker.

- Children enrolled in Medicaid are automatically enrolled in the Utah Statewide Immunization Information System (USIIS). If you do not want your children enrolled in this system, you must call the USIIS HelpLine at 801-538-6872 or the Immunization Hotline at 1-800-275-0659.

- **Cooperate**
  You must cooperate in any review of your case by Quality Control, Recovery Services, and the Bureau of Eligibility Services. You must also cooperate in providing information about any other sources of medical payments and obtaining medical support. If you feel you could be harmed by giving this information, you can request a 'good cause' claim. Your worker can explain this procedure.

  You and your household must also obey the medical assistance program rules.

BES **Department of Health**

Form 476

CHANGES YOU MUST REPORT

Remember that you are required to report changes in your situation within 10 days of the day you learn of the change. Do not delay reporting changes. Changes can effect your eligibility. If you receive benefits which you are not eligible to receive, you will have to repay that amount.

CHANGE IN INCOME SOURCE

Getting a job, terminated a job, changing jobs, working for temporary services, educational income, SSI, SSA, or unemployment compensation, etc. Receiving a lump sum settlement.

CHANGE IN EARNED OR UNEARNED GROSS MONTHLY INCOME

Working more OR less hours, overtime, getting a raise, terminating a job, etc. Change in SSI, SSA, Unemployment Compensation, etc.

CHANGE IN THE LEGAL OBLIGATION TO PAY CHILD SUPPORT

CHANGE IN MARITAL STATUS OR LIVING ARRANGEMENTS

Getting married, separated, or divorced; moving in with a roommate; absent parent moves in; birth of a baby or end of a pregnancy; household member moves in or out; death of a household member; etc.

GAIN OR LOSS OF A VEHICLE (LICENSED OR UNLICENSED)

Car, truck, van, motorcycle, camper, trailer, recreational vehicle, etc.

CHANGE IN ANY ASSET

Report changes in ownership or value of stocks, bonds, property, vehicles, life insurance, trust funds, burial plans, cash, opening and closing of bank accounts, etc. for all household members. (Includes joint ownership of any asset with spouse, parents, children, etc.)

CHANGE IN ALLOWABLE DEDUCTIONS

Child care expenses, health insurance expenses, etc. If you are age 65 or over, blind, or disabled, you must also report changes in alimony or child support paid by a spouse or parent and work related expenses.

CHANGE IN INSURANCE COVERAGE

Changes in access to insurance, coverage, or enrollment in any health coverage plan, including Medicare, for anyone in the household. You must also report accidents or injuries which may be payable by a third party.

Your Case Worker_____ Phone _____ Case #_____

UTAH DEPARTMENT OF HEALTH, DIVISION OF HEALTH CARE FINANCING

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. Effective: 04/14/2003

The Utah Department of Health, Division of Health Care Financing (DHCF) is committed to protecting your medical information. DHCF is required by law to maintain the privacy of your medical information, provide this notice to you, and abide by the terms of this notice.

CONFIDENTIALITY PRACTICES AND USES

DHCF may use your health information for conducting our business. Examples:

Treatment - to appropriately determine approvals or denials of your medical treatment. For example, DHCF health care professionals may review your treatment plan by your health care provider for medical necessity if a Medicaid recipient or for program listed services if a Primary Care Network (PCN) recipient or a Children's Health Insurance Program (CHIP) recipient.

Payment - to determine your eligibility in the Medicaid, PCN or CHIP program and make payment to your health care provider. For example, your health care provider may send claims for payment to DHCF for medical services provided to you, if appropriate.

Health Care Operations - to evaluate the performance of a health plan or a health care provider. For example, DHCF contracts with consultants who review the records of hospitals and other organizations to determine the quality of care you received.

Informational Purposes - to give you helpful information such as health plan choices, program benefit updates, free medical exams and consumer protection information.

YOUR INDIVIDUAL RIGHTS

You have the right to:

Request restrictions on how we use and share your health information. We will consider all requests for restrictions carefully but are not required to agree to any restriction.

Request that we use a specific telephone number or address to communicate with you.

Inspect and copy your health information, including medical and billing records. Fees may apply. Under limited circumstances, we may deny you access to a portion of your health information and you may request a review of the denial. *

Request corrections or additions to your health information. *

Request an accounting of certain disclosures of your health information made by us. The accounting does not include disclosures made for treatment, payment, and health care operations and some disclosures required by law. Your request must state the period of time desired for the accounting, which must be within the six years prior to your request and exclude dates prior to April 14, 2003. The first accounting is free but a fee will apply if more than one request is made in a 12-month period.*

Request a paper copy of this notice even if you agree to receive it electronically.

Requests marked with a star (*) must be made in writing. Contact the DHCF Privacy Officer for the appropriate form for your request.

SHARING YOUR HEALTH INFORMATION

There are limited situations when we are permitted or required to disclose health information without your signed authorization. These situations include activities necessary to administer the Medicaid, PCN and CHIP programs and the following:
For public health purposes such as reporting communicable diseases, work-related illnesses, or other diseases and injuries permitted by law; reporting births and deaths; and reporting reactions to drugs and problems with medical devices
To protect victims of abuse, neglect, or domestic violence
For health oversight activities such as investigations, audits, and inspections
For lawsuits and similar proceedings
When otherwise required by law
When requested by law enforcement as required by law or court order
To coroners, medical examiners, and funeral directors
For organ and tissue donation
For research approved by our review process under strict federal guidelines
To reduce or prevent a serious threat to public health and safety
For workers' compensation or other similar programs if you are injured at work
For specialized government functions such as intelligence and national security

All other uses and disclosures, not described in this notice, require your signed authorization. You may revoke your authorization at any time with a written statement.

OUR PRIVACY RESPONSIBILITIES

DHCF is required by law to:
Maintain the privacy of your health information
Provide this notice that describes the ways we may use and share your health information
Follow the terms of the notice currently in effect.
We reserve the right to make changes to this notice at any time and make the new privacy practices effective for all information we maintain. Current notices will be posted in DHCF offices and on our website, http://health.utah.gov/hipaa. You may also request a copy of any notice from your DHCF Privacy Officer listed below:

CONTACT US

If you would like further information about your privacy rights, are concerned that your privacy rights have been violated, or disagree with a decision that we made about access to your health information, Medicaid, PCN and CHIP recipients should contact the DHCF Privacy Officer, Craig Devashrayee, 801-538-6641; 288 North 1460 West, 3rd Floor, PO Box 143102, Salt Lake City, Utah 84114-3102; cdevashrayee@utah.gov.

We will investigate all complaints and will not retaliate against you for filing a complaint.
You may also file a written complaint with the Office of Civil Rights, 200 Independence Avenue, S. W. Room 509F HHH Bldg., Washington, DC 20201